Cardiol Young 2000; 10: 425–426

ISSN 1047-9511

Newsletter from the Association for European Paediatric Cardiology

What can we learn from numerical data?

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WITHOUT QUESTION, NUMERICAL DATA IS important. We have a saying in Holland "meten is weten", which translates to "measuring gives knowledge". It makes sense, therefore, to measure. But what are we doing with the results of our measurements? To take advantage of good measurement, we need to interpret properly the result, and in its appropriate context. Interpretation can always be done from different viewpoints. It is here where we run into potential problems with politics. It is becoming increasingly clear that we must ourselves become involved in politics if we are to optimise our practice. Let me give an example to illustrate the issue.

In the last number of this Journal, we presented numerical data concerning the activities of paediatric cardiologists and cardiac surgeons working in Europe over the year 1998.[1] What can we learn from these figures? If we look in detail, we discover that the number of diagnostic catheterisations performed in comparison to cardiac surgical procedures differed in the various countries of Europe. The differences varied from 26 to 114%, with an average of 77% (Fig. 1). This discrepancy existed already in 1991,

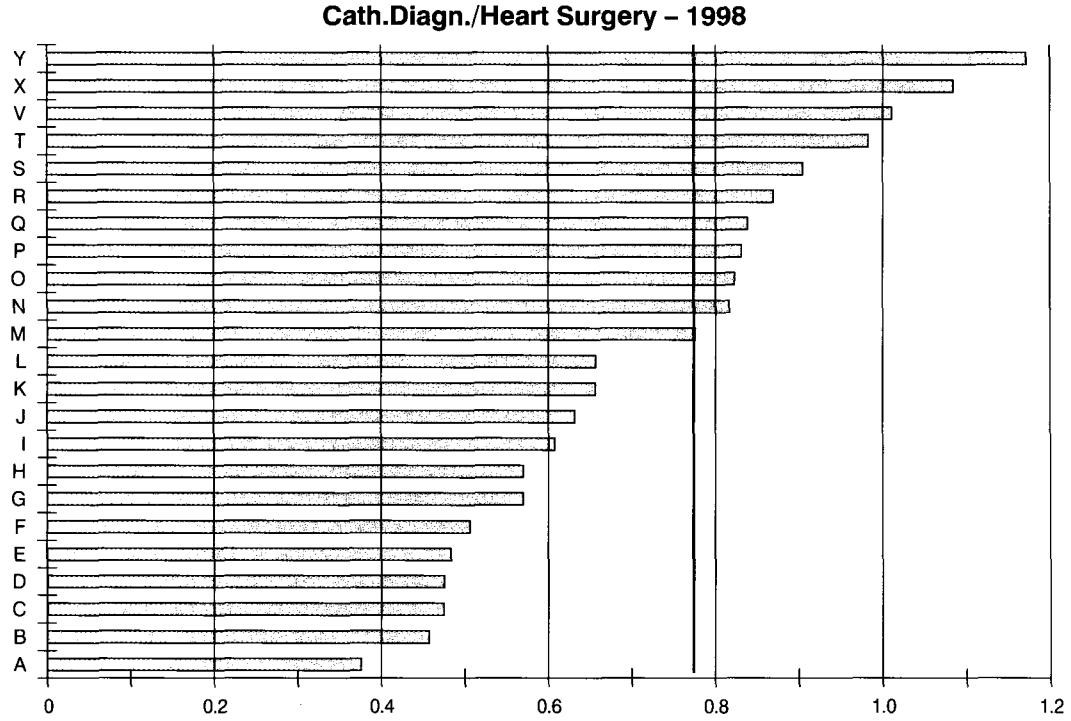

Figure 1.
The ratio of diagnostic catheterisations (cath.diagn.) as opposed to surgical procedures (heart surgery) in the different countries of Europe. The countries have been anonymised by identifying them with an arbitrary letter. The solid vertical bar at 0.77 is the average for Europe in 1998.

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although the average was then 86%. When making Figure 1, I purposely omitted identifying the countries themselves, because this information is not relevant. What we need to debate is the reason for the discrepancies and the way they may be interpreted. In the eyes of providers of health care, it could easily be concluded that too many diagnostic catheterisations are performed. The provider of health care, searching for areas of potential cost-reduction, would certainly draw this conclusion. But is this the case? One could say, "in country Y there is an excess of diagnostic catheterisations", but one could also say, "in country A, there are too few catheterisations". The best persons to adjudicate between these statements would be the paediatric cardiologists or congenital cardiac surgeons themselves. So, when we seek to evaluate the quality of our work, and this may include local and economic characteristics, we must be committed to these tasks as a profession. Otherwise, the entire process will be ruled by costs, because there will be no other way to influence the outcome. It is incumbent on the medical profession, therefore, to look for, to debate, to determine the values of the different procedures, and to produce reasoned opinions on their utility. Only the medical profession has the appropriate authority to evaluate these difficult questions. This process is part of professional medical development. Of course, we must also co-operate in this respect with all others involved in the provision of health care. Only in this way will we provide the optimal care for the individual patient.

In the past, the very process of evaluating continuous medical development was regarded by the profession with scepticism. We were afraid to be controlled. But most of us do not live on islands! Now, with the increase of co-operation, and co-ordination of work, between the different countries in Europe, involvement of the profession in the process becomes even more essential. Providers of health care from different countries are themselves communicating with each other. They can easily collect the data which, thus far, we have kept to ourselves. So, when we want to do proper medicine, we must involve ourselves with the process of evaluating, discussing, and finding the best solutions. I hope that, within our Association, there are skilled people willing to start this process.

Reference

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https://doi.org/10.1017/S1047951100009781 Published online by Cambridge University Press